February 13, 2009

SENATE BILL No. 472

DIGEST OF SB 472 (Updated February 11, 2009 2:40 pm - DI 104)

Citations Affected: IC 12-15; noncode.

Synopsis: Indiana check-up plan. Allows certain individuals to participate in the Indiana check-up plan (plan) without state funding. Allows a nonprofit organization and certain health care insurers and health maintenance organizations to contribute to the health care account of a plan participant under certain circumstances. Specifies that the minimum amount paid by certain plan participants into the participant's health care account is $60. Repeals a provision allowing individuals to obtain health care coverage that is the same as the plan if the plan has reached maximum enrollment using standard underwriting practices.

Effective: Upon passage; July 1, 2009.

Miller, Mishler, Sipes

January 14, 2009, read first time and referred to Committee on Health and Provider Services.
February 12, 2009, amended, reported favorably — Do Pass.

February 13, 2009

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

SENATE BILL No. 472

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-44.2-4, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.
(2) Inpatient hospital services.
(3) Prescription drug coverage.
(4) Emergency room services.
(5) Physician office services.
(6) Diagnostic services.
(7) Outpatient services, including therapy services.
(8) Comprehensive disease management.
(9) Home health services, including case management.
(10) Urgent care center services.
(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(b) The plan must do the following:

(1) Offer coverage for dental and vision services to an individual who participates in the plan.

(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1) **for an individual who participates in the plan under section 9(a) of this chapter.**

(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.

(d) Vision services offered by the plan must include services provided by an optometrist.

(e) The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

(f) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

SECTION 2. IC 12-15-44.2-5, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 5. (a) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(b) The plan shall, at no cost to the individual, provide payment for not more than five hundred dollars ($500) of qualifying preventative care services per year for an individual who participates in the plan **under section 9(a) of this chapter.** Any additional preventative care

services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

SECTION 3. IC 12-15-44.2-9, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 9. (a) **Except as provided in subsection (b),** an individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) An individual who:

(1) meets the requirements of subsection (a) but is not enrolled because the plan has reached maximum enrollment; or

(2) meets all of the requirements in subsection (a) except for subsection (a)(3);

is eligible to participate in the plan. However, the state does not provide funding for health insurance coverage provided under the plan to an individual who is described in this subsection.

~~(b)~~ **(c)** The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

~~(c)~~ **(d)** The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

SECTION 4. IC 12-15-44.2-10, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 10. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual.

(2) An employer.

(3) The state.

(4) A nonprofit organization if the nonprofit organization:

(A) is not affiliated with a health care plan; and

(B) does not contribute more than fifty percent (50%) of the individual's required payment to the individual's health care account.

(5) An insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan if the payment:

(A) is to provide a health incentive to the individual; and

(B) does not result in the account balance exceeding one thousand one hundred dollars ($1,100).

(b) The minimum funding amount for a health care account is the amount required under section 11 of this chapter.

(c) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.

(3) Another method determined by the office.

(e) An employer may make, from funds not payable by the employer to the employee, not more than fifty percent (50%) of an individual's required payment to the individual's health care account.

(f) An insurer or a health maintenance organization may offer a reward under a health incentive program administered by the insurer or health maintenance organization to a participant if the reward is disseminated in one (1) of the following manners:

(1) The reward is deposited into the individual's health care account.

(2) If the individual's health care account is fully funded, the reward may be provided directly to the participant.

(g) A person that makes a contribution to an individual's health care account under subsection (a) shall ensure that the person has not induced or required the participant to receive a health care

service from a specific health care provider or facility.

SECTION 5. IC 12-15-44.2-11, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 11. (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

(b) To participate in the plan, an individual shall do the following:

(1) Apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(2) If the individual is approved by the office **under section 9(a) of this chapter** to participate in the plan, contribute to the individual's health care account the lesser of the following:

(A) One thousand one hundred dollars ($1,100) per year, less any amounts paid by the individual under the:

(i) Medicaid program under IC 12-15;

(ii) children's health insurance program under IC 12-17.6; and

(iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office.

(B) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

(i) Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.

(ii) Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.

(iii) Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.

(iv) Five percent (5%) of the individual's annual household

income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.

However, the amount contributed under this subdivision must be at least sixty dollars ($60) per year. The office may allow the contribution to be made in a monthly installment payment of at least five dollars ($5).

(3) If the individual is approved by the office under section 9(b) of this chapter to participate in the plan, contribute to the individual's health care account:

(A) one thousand one hundred dollars ($1,100); and

(B) any other costs associated with the individual's participation in the plan.

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is less than one thousand one hundred dollars ($1,100).

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the individual may not reapply to participate in the plan for twelve (12) months.

SECTION 6. IC 12-15-44.2-14, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 14. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual that participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; ~~and~~

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the individual has met the coverage limitations described in section 6 of this chapter; **and**

(4) may not distribute information or materials related to a

specific health care provider or facility to an eligible individual or a participant.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 7. IC 12-15-44.2-16, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 16. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) does not meet the eligibility requirements specified in section 9 of this chapter for participation in the plan.

~~(b) An insurer, a health maintenance organization, or an affiliate described in subsection (a) may apply to health insurance coverage offered under subsection (a) the insurer's, health maintenance organization's, or affiliate's standard individual or small group insurance underwriting and rating practices.~~

~~(c)~~ **(b)** The state does not provide funding for health insurance coverage received under this section.

SECTION 8. IC 12-15-44.2-15 IS REPEALED [EFFECTIVE JULY 1, 2009].

SECTION 9. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the select joint commission on Medicaid oversight established by IC 2-5-26-3.**

(b) As used in this SECTION, "secretary" refers to the secretary of family and social services.

(c) Not later than September 1, 2009, the secretary shall report to the commission on the status of the following:

(1) The disproportionate share hospital payment system and any legislative changes needed for this system.

(2) The establishment of the enhanced payment group.

(d) This SECTION expires December 31, 2009.

SECTION 10. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 472, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 though 15.

Delete pages 2 through 17.

Page 18, delete lines 1 through 23.

Page 24, delete lines 23 through 42.

Delete pages 25 through 27.

Page 28, delete lines 1 through 35, begin a new paragraph and insert:

"SECTION 8. IC 12-15-44.2-15 IS REPEALED [EFFECTIVE JULY 1, 2009].".

Page 29, line 3, delete "group" and insert "**group.**".

Page 29, delete lines 4 through 6.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 472 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.